

Henry C. Lea

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CLINICS.

CLINICAL LECTURES.

Clinical Lecture on Croup, and the Diseases that resemble it. By Sir WM. JENNER, Bart., M.D., F.R.S., Prof. Clin. Med. in Univ. Coll. London. (Continued from p. 38.)

MEMBRANOUS inflammation of the larynx—inflammation, that is, attended by the presence of lymph on the surface of the mucous membrane of the larynx—is croup. This is a peculiar form of inflammation, as the presence of the lymph proves. If we produce inflammation of a mucous membrane by a direct irritant, we have, as the result, the formation of excess of mucus, or of pus, or of

both conjoined; we do not have lymph exuded. If we irritate directly a serous membrane, we may have excess of serum, or we may have pus or lymph produced. There must, therefore, be some peculiarity in the special inflammation of a mucous membrane which leads to the formation on it of a substance not formed when the inflammation is excited simply by a mechanical irritant. The inflammation is a so-called specific inflammation.

It was once supposed that membranous inflammation of the larynx was peculiar to children. It is now known that it is not so. It occurs, not so very unfrequently, in persons of advanced life. Diphtheria is an acute specific disease attended by inflammation of the pharynx, having

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as its result exudation of lymph. It is a specific inflammation arising from a specific cause. The specific inflammation in diphtheria has a tendency to spread, to spread over the pharynx in all directions, to pass upwards to the nares, downwards to the larynx, and, in rare cases, to the œsophagus and stomach. From the pharynx it may spread down the trachea and into the bronchi. So that in diphtheria we get, not unfrequently, membranous inflammation of the larynx. But membranous inflammation of the larynx, I have told you, is croup. Is there, then, a membranous inflammation of the larynx distinct from the acute specific disease diphtheria? Are there a true croup and a diphtheritic croup? Certainly, if you were to place in the hands of the best pathologist the larynx of a child who had died from membranous inflammation of the larynx, the so-called idiopathic croup, and that of one who had died from a true diphtheritic inflammation of the larynx, he would be unable to distinguish the one from the other. There is no anatomical character by which he could say, "This is true croup; this is diphtheritic inflammation of the larynx." If, however, the pharynx was also found to be the seat of exudation of lymph, he would say, "This is undoubtedly diphtheritic inflammation of the larynx." But it is beyond question that true diphtheritic inflammation may be limited to the larynx; that, in exceptional cases, the pharynx escapes the exudation. Seeing, then, that there are no anatomical characters to distinguish the one disease from the other, are there any clinical characters by which the two affections may be separated? It has been supposed that the presence of albumen in the urine would be sufficient, and I formerly laid much weight on this distinction. But later years have satisfied me that in cases which present all the characters of true croup, which are sporadic, spread to no other person in the house, come on apparently from exposure to cold and damp,—that in such cases albumen may be present in the urine. It has again been urged that true croup has no tendency to spread; but this manifestly should no

more separate a single case from the diphtheritic croup than should a single case of scarlet fever, because it did not spread, be separated from other cases of scarlet fever. The cause, again—the fact that some cases of croup come on after distinct exposure to cold and wet—cannot be sufficient to separate croup from diphtheritic croup, for it is beyond question that a considerable number of cases of diphtheria do, to all appearances at least, date their origin from exposure to cold and wet. I have seen several solitary cases of true diphtheria thus originating; not spreading, or spreading, to other persons in the house, as the case may be. So my opinion has undergone some modification, and I am inclined now to the belief that there is no such disease as idiopathic, simple, membranous inflammation of the larynx. I say, I am inclined to this belief. I am not sure that it is true; but as I formerly thought that the weight of evidence was in favour of their non-identity, I am now inclined, from my further experience, to think that the two diseases are really identical, that the so-called croup is really diphtheria.

Membranous inflammation of the larynx is one of the gravest diseases; it kills rapidly. If the termination be fatal it usually is so within a few days from the outset; rarely does the disease last a week, supposing that the windpipe has not been opened. The disease is usually preceded by uneasiness in the pharynx, sometimes by well-marked evidences of diphtheria; often, however, the pharyngeal symptoms are trifling, and the gravity of the illness is only appreciated when the child wakes in the night with croupy breathing—that is, with rough, hoarse, loud, lengthened inspiration. The difficulty of inspiration is due to two causes. At first it is due to the swollen condition of the mucous membrane, and also largely to the superadded spasm. Subsequently it is due to the false membrane narrowing the passage, and also largely to the superadded spasm. The paroxysms of difficulty of inspiration from which the patient suffers are due to the spasm. The disease is attended by a certain amount of febrile disturbance, and

there is a little uneasiness in the larynx, perhaps some pain and tenderness. The lymphatic glands adjacent to the larynx are commonly enlarged and tender. (They require to be felt for.) There is hoarse, rough cough, with expectoration of at first a little glairy mucus, and subsequently pieces of false membrane—that is, of tough lymph.

The seat and character of the disease are manifested by the severity of the symptoms and their continuousness. That it is diphtheritic in origin is *proved* if one can find any trace of false membrane in the pharynx. Sometimes the pharyngeal membrane is greatly swollen, red, puffy-looking, and a tough mucus is spread pretty evenly over the surface. In other cases, whilst the pharynx exhibits no unequivocal false membrane, there is a discharge from the nose of serous acrid fluid, and on inspecting the nares you may see false membrane on the inflamed surface. But, believing as I do now that all croup is but a local manifestation of the general disease diphtheria, it would matter but little, as regards the diagnosis, whether the pharynx were the seat of membranous inflammation or not.

The child usually gets a little sleep towards the first morning, and seems rather better during the day—i. e., its breathing is less distressing. Its voice, however, never ceases to be hoarse, the cough never loses its clang, the impediment to the entrance of air never disappears. The recession of the soft parts of the chest walls never ceases to occur at each inspiration. It is only a question of more or less. As night comes on the patient is usually again worse, and although there may be again a little remission the following morning, there is, on the whole, a steady advance. When death occurs, it does so from one of several causes. It may be that the patient dies in a paroxysm of difficulty of the entrance of the air. There has been a certain amount of lividity, considerable recession of soft parts, and then, either during a paroxysm or in the interval between the paroxysms, death occurs in an instant. In some of these cases the final occlusion of the larynx is the result

of spasm. In other cases, a portion of false membrane partially detached blocks the way, and the patient may also die in an instant. The portion of false membrane does not permit, or only partially prevents, the escape of the air, but forbids its entrance; it acts as a valve. Again, the patient may die from the extension downwards and to the bronchi of the inflammation, the narrowing of the bronchi, the extension perhaps of the false membrane even into the capillary tubes. Again, the patient may die from pneumonia, lobular or lobar, the pneumonia arising from the patient inspiring small particles of false membrane or acrid matter into the finer capillaries or perhaps the air-cells themselves, and the matter thus inhaled setting up local inflammation. These cases are analogous to the cases of lobular pneumonia secondary to the spread through the circulation of pus or of minute particles of fibrin, etc. In the latter case, an irritant is carried by the blood, becomes arrested by the capillaries of the lung, and each particle becomes the centre of a patch of pneumonia. In the former case, it is the acrid matter exuded into the larynx and bronchi which passes down the air-tubes, is arrested at their termination, and becomes the centre of a local inflammation. The facility for the occurrence of this blocking up of the lung by inspired particles is the greater because the patient loses considerably the power of coughing. He is unable to close his larynx sufficiently to cough effectually. His cough is rather a hawking-up than a true cough. For a true cough to occur, you know that the lungs must be filled with air, and then the glottis closed, so that the air in the substance of the lung may be compressed violently, and then the glottis be suddenly opened. But the patient who cannot close his glottis well cannot cough perfectly, and substances inspired are drawn in a little way at each inspiration, further than they can be expelled by the imperfect expiratory cough.

To avert death in cases of membranous exudation into the larynx we open either the larynx or the trachea: the trachea in a child; the larynx in an adult. We select the larynx in an adult because of the

facility with which it is reached. We are driven to open the trachea in a child because the larynx is too small to admit the tube. The opening into the windpipe still further interferes with the power of coughing. The patient, in croup, is, as I have said, unable to close his larynx well; still he can close it to a certain degree, and he is able to cough to that degree. The tube of course he is unable to close, and hence acrid matters about the tube are more liable to be drawn downwards, and therefore to become impacted in the lung, to produce pneumonia, and, in their passage downwards—so acrid is the matter—to produce bronchitis. It must be remembered that the inflammation extends downwards, not merely because the inflammation itself has a tendency to spread, but because the matter thrown out is acrid, and has a tendency to produce inflammation, which, in the constitutional state of the patient, will be membranous inflammation. Thus, in some cases of diphtheria, the ear is the seat of membranous inflammation, and acrid matter as well as lymph is poured out. It runs down the outer side of the ear. As it passes down it excites inflammation, and the inflamed surface becomes covered with a false membrane. That this false membrane is not the result merely of extension of the inflammation is probable from the fact that if a blister is applied to a person suffering from diphtheria the raw surface frequently becomes covered with lymph, with a false membrane, with a diphtheritic exudation. You will thus understand that the fluid exuded is an irritant; that this irritant produces inflammation; that the inflammation, in the constitutional condition, is attended with an exudation of lymph. It is a specific inflammation, because the person is suffering from a specific disease, just as, when a person is the subject of constitutional syphilis, the local inflammations assume frequently a syphilitic character, or, in the subject of cancer, local injury may cause changes of texture cancerous in nature.

This leads me to a point of some practical importance in regard to tracheotomy. It is commonly stated that the bronchitis

which so frequently follows tracheotomy in diphtheria is the result of the entrance of the cold air through the tube. It is said that in ordinary breathing the air is warmed as it passes through the mouth and nose and the pharynx and larynx, and so it is warmed air only which comes in contact with the bronchial tubes; that the entrance of cold air excites inflammation, and hence that many patients operated on for tracheotomy in croup die from bronchitis. To prevent this entrance of cold air, and I should say also of dry air, the patient's bed is surrounded with blankets, and a tube discharging moist vapour is introduced within the blanket-curtains, so that the patient may breathe a warm and moist air.

It seems to me that, if the explanation I have given you be correct, there is no need for these special means—for these blankets and hot vapour. We know that if the larynx be opened for any other affection—for example, such a case as we have now in the hospital—there is no tendency to the occurrence of bronchitis, and the patient walks about and breathes the ordinary air, with very little protection, and without danger. A little protection may be necessary. Not only are these special means unnecessary, but in the disease diphtheria they are most injurious. They are most injurious because they tend to produce that exhaustion which is the cause of the fatal termination in so many cases during the second week of their illness. The relief which the patient experiences when you remove all this apparatus is marked. You must have seen it in the woman to whom I have referred. Thus you will understand that I think it most important for the success of the treatment of croup, should tracheotomy be performed, that the patient should be kept in a moderately warm atmosphere, a moderately moist atmosphere, but an atmosphere only so moist as may be produced by a kettle on the fire throwing a little moisture into the room, only so warm as shall be agreeable to the patient. I am sure that I have seen cases terminate fatally that would have recovered had they not been thus over-nursed, over-cared-for; had,

that is to say, the origin of the bronchitis been properly appreciated.

Holding the views which I now do, you will see at once that I should discard from the treatment of croup all those heroic remedies that were formerly regarded as indispensable—leeching, mercurializing, antimonizing; and I should advise you to treat them on the same principles as you would treat diphtheria with exudation, commencing in any other part—opening the larynx, however, if death is threatened by its occlusion.

Edema glottidis, effusion of serum into the cellular tissue of the larynx, and especially of the aryteno-epiglottidean folds, although it may come on and does come on as an acute illness, is always secondary to some other affection, commonly to chronic disease of the larynx. If life be threatened by it, and the part be not relieved by puncture with the nail, or, if well within reach, by a lancet, then laryngotomy in the adult, tracheotomy in the child, is the remedy. Usually the part is well within sight, and by the use of a tongue depressor and by the aid of the finger there is not much difficulty in the diagnosis. The rapid, sudden development of extreme dyspnoea leads you at once to examine the part. You have only to be aware of the possibility of its occurrence to avoid an error in diagnosis, and you have only to know of its existence to determine its treatment. There is a large quantity of fluid accumulating about the entrance to the larynx; it is within reach of the finger, and can in many cases be let out. If it cannot, drugs are useless, and you must avert death by letting in the air below the point of obstruction.

In regard to an inflamed cyst, the finger and the eye are the aids to diagnosis. The finger will at once give you every necessary information. You feel a rounded smooth surface; you feel its connection with the margin of the epiglottis; you feel it extending backwards; you can trace, in fact, with the finger, all its relations without difficulty. The smooth elastic swelling and the feeling of fluctuation communicated to the finger are not, so far as I know, simulated by any other affection. The remedy is as certain as

the diagnosis. With a lancet or a bistoury open the cavity, and the escape of the fluid affords immediate relief. Here, again, the great point is to be aware of the existence of such a trouble. Suspect, and there is no difficulty in the diagnosis.

A collection of pus in the cellular tissue on one side of the larynx I have seen cause very great distress to the breathing by compressing the larynx. I have seen a child brought within a few hours of death from this cause. The diagnosis is not always easy. There may be no redness of the surface, and the general restlessness and distress render, in the child, the presence of pain doubtful. There is, perhaps, a little general fulness of the part; and it requires careful examination, careful manipulation, to determine the nature of the trouble. The larynx is pushed over a little to one side, and this should at once arrest attention and direct the physician to the seat of the disease. Once having his attention fixed on the seat of the disease, the rapidity of the development of the trouble, the uneasiness and tenderness in the region before the difficulty of breathing commenced, will render the nature of the case probable; and a careful handling of the part will make the diagnosis certain. To overlook the abscess, to leave it unopened, may lead to the patient's death; the relief on opening is instantaneous.—*Lancet*, Jan. 16, 1875.

HOSPITAL NOTES AND GLEANINGS.

Two Cases of Epididymitis, treated with Ice and small doses of Tartar Emetic with Epsom Salts.—Of the early sequelæ of gonorrhœa, there is none which occasions more suffering to the patient, or entails more trouble upon the medical attendant, than acute inflammation of the testis, or rather of the epididymis; and of all local measures recommended for its subdual, fomentations, alone or after leeches, are perhaps now in most favour. The employment of leeches, however, is discountenanced by some justly reputed authors, who allege that leeches often increase the swelling of the scrotum, whilst they do

not materially shorten the duration of the attack. The practice of puncturing or making a cut into the inflamed organ with a bistoury for the purpose of relieving tension by division of the fibrous coat, originally recommended by Vidal de Cassis, and now advocated by some metropolitan surgeons, has not found many followers. The practice, in Mr. Hulke's opinion, is not so harmless as its chief advocate would have us believe; whilst it is, he says, incontestably inferior to the methodical application of ice—a measure which is harmless in itself, and superior also to fomenting and leeching. The caoutchouc ice-bags introduced by Professor Esmarch leave nothing to be desired. Mr. Hulke recommends that the scrotum should be elevated on a small, firm pillow put between the thighs, covered with one or two folds of dry rag (a precaution never to be omitted), and an India-rubber bag half filled with ice broken into small pieces laid upon it. Constant renewal of the ice, when it has melted, should be very strictly enjoined. This measure of itself will generally very quickly relieve the severity of the pain and great tenderness, so that after twenty-four hours the testis cannot infrequently be strapped; but its influence will be considerably assisted by the administration of small doses of tartar emetic with sulphate of magnesia, repeated at short intervals until they nauseate and purge, when their exhibition should be stopped.

1. A short, thin, swarthy labourer, aged twenty-seven, had a clap. In the third week, when the urethral discharge had become gleety, he fell whilst lifting a sack of corn; and soon after this his left testicle swelled and became excessively painful.

When admitted into Middlesex Hospital under the care of Mr. Hulke, the tenderness and the painfulness of the testis were so extreme that he walked hesitatingly, straddling his legs and bending his trunk forwards, so much did he dread any contact of the thigh with the inflamed organ. The epididymis, particularly its tail, was the part which was inflamed, the testis itself being scarcely swollen. The scrotum was red and cedematous. The patient

was ordered to bed, the scrotum was raised upon a cushion, and a caoutchouc bag of ice was placed on it. The man was enjoined to ask for renewal of the ice whenever he should find it had melted. One-eighth of a grain of tartar emetic, with one drachm of Epsom salts, in an ounce of water, were ordered to be taken every half hour until nausea and purging were produced, upon which they were to be discontinued. Next day the swelling was much less, the scrotum also was corrugated, and no longer red. There was no pain, and but very little tenderness, so that the patient could bear handling of the testis. He was ordered to continue the ice during this day, and in the evening to discontinue it. The ice-bag was to be left on the scrotum for some time after the last ice had thawed, so that the temperature might rise slowly. If any pain returned, the ice-bag was to be at once replaced. On the third day the testis was strapped. Two days later, the strapping having become very loose, it was renewed; and on the sixth day after entering the hospital he was discharged convalescent as regarded the epididymitis. The testis with its epididymis was soft, neither tender nor painful, and scarcely appreciably larger than its fellow.

2. A porter, aged twenty-one, was admitted into Middlesex Hospital on Dec. 5th with the right testis, but especially its epididymis, very swollen, tender, and painful, and scrotum red and cedematous. Upon the front of the testis was a particular tender fluctuating spot, with hardness around it; and there was a thin, gleety, urethral discharge. The patient was ordered to take the same mixture as in the last case, at intervals of half an hour. After ten doses he was sick and purged, and the medicine was discontinued. The scrotum was raised on a pillow, and an ice-bag was placed on it. Next day the swelling, redness, pain, and tenderness were very much less. On Dec. 8th the fluctuation was not so apparent. On the 11th no fluctuation could be detected. The pain and tenderness had quite gone for a couple of days. The testis was strapped, and the strapping was subsequently twice

renewed. On the 18th the patient was discharged convalescent.

In this case, in consequence of an abscess threatening (an unusual circumstance), the ice-bag was kept on longer than in the first case, and, as the result showed, with the happiest effect.—*Lancet*, Jan. 23, 1875.

Fracture of Outer Condyle of Femur, simulating Fractured Patella.—J. C—, a stonemason, aged sixty-eight, whilst clinging to a rope in order to put some pulleys right, lost his hold, and fell about twelve feet; his right knee, which was bent, coming violently in contact with the ground. On attempting to rise he was unable to do so, and was therefore at once carried to the hospital.

On admission on Nov. 8 into St. George's Hospital, under the care of Mr. PRESCOTT HEWITT, the patient complained of great pain in the right knee and inability to move the joint. The leg on the affected side was semiflexed, and there was some effusion into the knee-joint, on the outer side of which there was a bruise. When the hand was placed on the front of the joint, two movable pieces of bone could be felt, lying one above the other, with a depression between them in which a finger could be placed. Of these two pieces the lower was considerably larger than the upper. These signs at first sight seemed to indicate a transverse fracture of the patella through its upper part, but on closer examination this bone appeared to be entire. The upper portion of bone was a little to the outside of the lower, and on rubbing the pieces together no crepitus could be felt. On feeling for the lower border of the external condyle of the femur, and tracing it forwards, it seemed to terminate abruptly; and now, when the loose bone lying above the patella was pressed backwards and rubbed against the external condyle, crepitus was very easily obtained.

The patient was sent to bed, and a ham splint put at the back of the limb, which was swung in a Salter's swing. After this he did well; and as the effusion in the synovial membrane disappeared, which it did at the end of a week, the

portion of bone which had been chipped off gradually fell back, came into contact with the broken surface of the femur, and in a month was firmly united in its original situation.—*Lancet*, Feb. 13, 1875.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Specialities in Medicine.—Dr. JACOBI, chairman of the Committee on the President's Address (New York State Medical Society), in his report made the following well-timed and just remarks on specialities of medicine, and we ask the attention of our readers to them.

"The general remarks of our President on the extinction of four hundred and fifty journals in the United States and Canada, and the unnecessary subdivision into specialities ought not to go unheeded. It is a matter of sincere congratulation on the part of all of us that those four hundred and fifty journals died so early, when there was no nerve-centre, no viability in them. Let us hope that many more of the same class will speedily fulfil their natural destination. We still have a large number of journals which express and contain nothing besides the desire of the editor or editors for notoriety, the title-page being the only original article, and the contents exhibiting the results of an active pair of scissors. Such publications, if they contrive to exist for any length of time, lower the tone of medical literature, demoralize particularly the younger members of the profession whose legitimate ambition and zeal are suppressed by beholding the facility with which notoriety is obtained, and diminish the chances of development on the part of better journals. This influence on the younger members of the profession ought not to be underrated. While they hope for success, they must look for the means of obtaining it. There are but few mortals whose ambition, both intellectual and moral, extends beyond the accomplishments and success of the best and most successful around them; but few who learn for the sake of knowledge, and work from inner necessity. Thus it is, that so many of them are blinded by the success

of older specialists to the manner in which these became not only specialists, but noted and successful men. They are too apt to believe, that to be successful nothing is requisite but to be specialists. Therefore they are apt to rush into a speciality as soon as, or before, they graduate, neglect general medical knowledge, and miss their aim, both scientifically and pecuniarily, because they ignored the fact that their admired examples were medical men before they were specialists, and went, so to say, with a large capital, and all their mind, into a special business. It is true that the *progress of medicine depends on the continued efforts of specialists*. But those who have contributed most to the advancement of our science, were men who did not select a special work before mastering the domain of universal medicine, but selected it on the foundation of a general thorough education and knowledge. The brief remarks of the President, your Committee consider very timely indeed. While they do not disparage special studies and specialities of practice, they contain a wholesome warning against the heedless neglect of general medicine. Special journals, finally, while—when thoroughly scientific—they will not command a large sale, are *not only valuable but necessary*.”—*Medical Record*, Feb. 27, 1875.

University of Pennsylvania; Auxiliary Faculty of Medicine.—The tenth annual course of lectures will commence on Monday, March 22d, and will continue until June 12th. Three lectures a week will be delivered by each professor; and, in order the more fully to meet the engagements of the students, the lectures will be given in the afternoons.

The trustees of the University have authorized the conferring of the degree of Doctor of Philosophy (Ph.D.) upon graduates of medicine of the University of Pennsylvania, or of other medical schools upon the *ad eundem list*, who shall have attended two full courses of lectures by the auxiliary faculty, and have passed a satisfactory examination before this faculty.

The faculty consists of Harrison Allen, M.D., Professor of Zoology and Comparative Anatomy; Horatio C. Wood, Jr., M.D., Professor of Botany; Henry Harts-horne, M.D., Professor of Hygiene; John J. Reese, M.D., Professor of Medical Jurisprudence, including Toxicology; Samuel B. Howell, M.D., Professor of Mineralogy and Geology, and Dean.

Obstetrical Section of the American Medical Association.—We have been requested to announce to those who have papers to read before this Section at the next meeting, to forward them either to Dr. Byford at Chicago, or to Dr. S. C. Busey at Washington, in order that proper arrangements may be made for their reading.

Medical Graduates in 1875.—

University of Pennsylvania . . .	100
Jefferson Medical College (Phila.) .	170
College of Physicians and Surgeons, New York	108
Bellevue Hospital Medical College, New York	194
University of the City of New York	95
Syracuse University	21
Yale College	7
University of Maryland (Baltimore) College of Physicians and Surgeons, Baltimore	50 39
Medical College of Ohio (Cin.) .	101
Cincinnati College of Medicine and Surgery	28
Rush Medical College (Chicago) .	77
Nashville and Vanderbilt University	58
Louisville Medical College . . .	83
Louisville Hospital College of Medi- cine	56

Philadelphia College of Pharmacy.—At the 54th annual commencement of this school, held on the 16th of March, the degree of “Graduate of Pharmacy” was conferred on 82 candidates.

American Clinical Lectures.—G. P. Putnam's Sons have commenced the publication of a series of Clinical Lectures, edited by E. C. Seguin, M.D., which it is announced are to be by representative American teachers upon topics of prac-

tical interest. Two of these have appeared, one, "On Disease of the Hip-joint, by Lewis A. Sayre, M.D.;" the second, "On Acute Rheumatism in Infancy and Childhood, by A. Jacobi, M.D." Both of these lecturers are authorities on the subject they discuss. The enterprise deserves encouragement.

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OBITUARY RECORD.—It is with profound regret that we record the death on the 4th of March last, at his residence in this city, in the 67th year of his age, of our valued friend GEO. W. NORRIS, M.D., Vice-President of the College of Physicians of Philadelphia.

Dr. Norris was a thoroughly instructed and skilful surgeon. He enjoyed the highest reputation for sound surgical judgment, and his counsel was frequently sought. For thirty years he was one of the surgeons to the Pennsylvania Hospital, and the large experience there gained with his laborious investigation of the hospital statistics was embodied in various articles published in the *American Journal of the Medical Sciences*, and subsequently collected in a volume under the title of "*Contributions to Practical Surgery.*"

He was among the first in this country to employ the statistical method of investigation as applied to surgery, and is perhaps most extensively known by his essays on the "*Statistical Results of Operations upon the Larger Arteries,*" and upon "*Fractures and Amputations,*" as shown by the records of the Pennsylvania Hospital, and by his able paper "*On Ununited Fractures.*"

As a man, Dr. Norris was as much respected for his personal character as he was esteemed for his skill as a surgeon. His character was spotless, and may be advantageously held up as a model for imitation. Modest, courteous, dignified, charitable, and high minded to a chivalric degree, he was beloved by all who knew him, and it may be truly said that in the whole course of his life his conduct was beyond reproach. The appreciation in which he was held in his native city is, to some degree, shown by the numerous and important positions of honour and trust

which were conferred on him; among which may be mentioned that of Vice-President of the College of Physicians of Philadelphia, President of the Board of Managers of the University Hospital, Trustee of the University of Pennsylvania, Vice-President of the Alumni Association of the University of Pennsylvania, Consulting Surgeon to the Children's Hospital of Philadelphia, and to the Orthopaedic Hospital, President of the Historical Society of Pennsylvania, Member of the Société Médical d'Observation of Paris, and of other scientific and learned societies.

"At a special meeting of the College of Physicians of Philadelphia, held March 6, 1875, the following resolutions were unanimously adopted:—

"*Resolved*, That the Fellows of the College of Physicians have, with sincere sorrow and unusual emotion, heard of the death of Dr. George W. Norris, the Vice-President of the College, which occurred on March 4, after a long and painful illness.

"*Resolved*, That, while submitting with reverence to the decree of Providence depriving them of one of their most esteemed associates, they cherish the consolation that regret for the loss sustained in his decease is accompanied by imperishable recollections of his personal worth.

"*Resolved*, That the Fellows of the College have been deeply impressed by the courteous and gentle bearing of their late Vice-President, by his honourable conduct and high tone in his relations with his associates, by his studious avoidance of everything incompatible with the dignity of the profession of medicine, and by his entire freedom from all invidious personal assertion, while fully appreciative of the obligations of duty.

"*Resolved*, That they regard his life and professional career as models worthy of imitation, and as eminently illustrative of the principles which have animated the conduct of the great and the good men of our profession.

"*Resolved*, That his memory will be ever venerated for his whole-souled devotion to the interests of the profession, for his faithful maintenance of them, and for

his life-long endeavour to promote the advancement and efficiency of that profession by his personal contributions."

—, died, in New York, on the 13th of Feb. last, EDWARD DELAFIELD, M.D., LL.D., aged eighty-one.

Dr. Delafield graduated at Yale College in 1812, and four years afterward received his Medical degree from the College of Physicians and Surgeons, New York. Nine years later he was appointed Professor of Obstetrics in that institution, a position which he held until 1838, when increasing private practice compelled him to resign it as well as the post of Physician to the New York Hospital. In 1842 he founded the Society for the Relief of the Widows and Orphans of Medical Men, and was its first President. At the time of his death he was President of the College of Physicians and Surgeons, and of the Board of Governors of the Roosevelt Hospital.

In 1821, in conjunction with Dr. J. Kearney Rogers, he instituted the New York Eye Infirmary, the first special Institution of the kind in this country, preceding the Pennsylvania Infirmary for Diseases of the Eye and Ear by a few months.

FOREIGN INTELLIGENCE.

Deaths from Chloroform.—Surgeon-Major C. E. SMITH reports (*Lancet*, Feb. 13, 1875) the case of a bombardier, aged 19, who underwent an operation for the removal of the third toe which was ankylosed. Heart was healthy. One drachm of chloroform was administered on lint, and then two drachms, and the patient came under its influence without struggling or undue excitement. A fourth drachm was poured on the lint just before the operation commenced, but was only partially inhaled, as the patient became fully under the influence of chloroform immediately after, and the lint was at once laid aside. At this moment both the pulse and respiration were good. Suddenly, just as the operation was complete, which I should say was in about four minutes, the pulse suddenly failed, and the face became pale and livid. I immediately gave the alarm to Dr. Kilroy, who

ordered the window to be thrown up, water was dashed over the chest, and the pillows were removed from under the head. During this time respiration was still going on, for a few seconds stertorous, but subsequently sighing, and becoming gradually fainter, until at last the strong liquor ammoniæ was applied to the nostrils to excite respiratory action, and frictions to the extremities, with brandy, also kept up. Still no return of the pulse. Artificial respiration was then resorted to, and kept up until two other medical officers, who had been sent for from another part of the hospital, arrived, by whom it was suggested that the method adopted by Nélaton, and lately reported on in this country, should be adopted—viz., inversion of the body. This was immediately carried out, and kept up for over an hour. Galvanism was also resorted to at the same time. Respiration had quite ceased, and the man appeared to be quite dead before this; still some hope was entertained that the success which attended in the cases referred to might also again happen. But, to our deep regret, such was not the case; not the least flutter of the pulse or attempt at respiratory action was again observed, and we were reluctantly compelled to desist from our efforts to restore life.

Another case is reported in the *British Medical Journal* for Feb. 27, 1875. The victim was a male, aged 56, who was admitted into the Sheffield Public Hospital, suffering from epithelioma of the tongue. His heart being healthy, chloroform was administered Feb. 19, prior to the removal of the tongue by the galvanic cautery. Three drachms of chloroform were administered; at the end of ten minutes, the respiration became irregular and then ceased, the heart continuing to beat some little time thereafter. At the autopsy nothing was found to explain the death.

Chloroform Poisoning: Resuscitation by Nélaton's Method.—Dr. FREUZAL reports (*Progrès Médical*, Jan. 30th) a case in which a child, apparently dead from the administration of chloroform, was recalled to life by inversion and suspension by the feet, and forced movements of the chest.

The case forms an interesting pendant to those related recently by Dr. J. Marion Sims and Sir J. Rose Cormack. The lips and face were discoloured, and there was neither heart-action, pulsation, nor respiration. The effect of inversion was very rapid, and markedly effective.—*Brit. Med. Journ.*, Feb. 13, 1875.

Glycerine in Diabetes.—Diabetic patients lose a great deal of sugar, which in a state of health would be changed into carbonic acid and water. A great deal of respiratory heat is thus lost, and the patient must therefore use adipose matter and protein compounds for breathing purposes. To save the protein matters, glycerine is administered, since it has been shown by physiologists that it cannot be transformed into sugar within the economy, but is ultimately changed into carbonic acid and water. Thus respiration is supplied, and no tissues actually wasted. It is stated in the *Mouv. Méd.* of Jan. 23d, 1875, that Prof. Schultzen gives in such cases from six to eight drachms of glycerine per diem. The remedy should be continued uninterruptedly for one month, the doses remaining the same, as large ones are apt to give rise to diarrhoea.—*Lancet*, Feb. 20, 1875.

Treatment of Scabies.—Dr. F. W. CLEMENS, of Rudolstadt, recommends (*Allgemeine Medicinische Central-Zeitung*, Dec. 9, 1874) inunction with arsenic as a means of destroying the acarus of itch. The following are the proportions of the ingredients in his formula: Arsenous acid, 1 part; carbonate of potash, 20 parts; soap-spirit (soap-liniment?), 200 parts; water, 2000 parts. Some of this is rubbed into the affected parts twice daily. The carbonate of potash increases the solubility of the arsenic, and prevents too rapid desiccation; and the soap-spirit facilitates the passage of the remedy into the cuticle. Dr. Clemens says that he has tried this treatment for five years with complete success, and without having on any occasion observed gastric disturbance or any other ill effect.—*Brit. Med. Journ.*, Feb. 27, 1875.

Forcippressure.—M. VERNEUIL, the eminent Professor of Surgery at the Paris Faculty, has lately revived the practice of arresting hemorrhage by means of forceps left *in situ* where a ligature cannot be applied. He shows that, since the middle of the eighteenth century, surgeons have had recourse to forcippressure, either by instruments devised for the purpose, or by means of any compressing apparatus just at hand. M. Verneuil himself has succeeded in a remarkable manner in arresting hemorrhage in the way indicated, where the finding of the bleeding vessel was out of the question. Every surgeon knows how useful "bulldogs" frequently are, the advantage of the forceps over them being that the former can be carried to a greater depth. Nor should it be forgotten how often the sharp hook is advantageously used for raising a bundle whence the blood proceeds. One is also forcibly reminded of Simpson's acupressure, and of Vanzetti's unciopressure; but Prof. Verneuil's recommendation ought also to be borne in mind, and forceps, with continuous pressure, should always be at hand.—*Lancet*, Feb. 6, 1875.

Delay in the Coming away of Ligatures.—M. GUÉNIOT, at a recent meeting of the Société de Chirurgie, exhibited a boy, æt. 6, for whom he had performed amputation of the arm by the flap operation, on account of a white swelling of the elbow. The wound united by first intention almost throughout its entire course, but, although sixty-six days had elapsed, the ligature which was passed around the brachial artery had not come away, notwithstanding even energetic traction. However, as M. Guéniot, wishing to demonstrate the fact to his colleagues, drew upon the ligature rather forcibly, it to his surprise became at once detached. Having asked his colleagues for an explanation of this delay, M. Dubrueil suggested that the ligature had become imprisoned in the cicatricial tissue. M. Verneuil observed that he had not infrequently met with analogous cases, and had remarked that the adhesion of the ligatures bore an inverse relation to the amount of inflam-

mation which existed in the wound; the less the inflammation, the longer the adhesion of the ligature. He had seen ligatures applied after the removal of the breast, that could not be detached a month or six weeks after the operation. So, too, metallic sutures may persist for an indefinite time, owing to the little irritation they excite in the tissues. Several surgeons, indeed, have renounced their employment in consequence of these interminable delays. In M. Guéniot's case, immediate union of the wound had taken place at once, and the absence of inflammation explains the difficulty in removing the ligature. M. Perrin, while agreeing with M. Verneuil's opinion, believed that there may have been more than one cause at work, experience having shown him that delay in the fall of ligatures depends, in some cases, on the fact that fibrous tissue has been included in the ligature. M. Desprès agreed in this view, and had also observed in some cases that the ligatures have been detained amidst cicatricial tissue, or within a mass of granulations. M. Guéniot remarked that, if M. Perrin's explanation held good, we ought, in applying a ligature, to endeavour to include with it some of the adjoining tissues, in order to prevent its premature detachment, and the occurrence of secondary hemorrhage. This, M. Trélat considered, would be to return to the principle of the mediate ligature, which has been condemned in modern practice. When ligatures are slow in coming away, they are often retained by fibrous tissue, and in some cases by small fragments of the bone of the stump in the vicinity of the artery. M. Verneuil observed that the premature discharge of ligatures usually depends upon excess of inflammation in the stump. When the wound goes on well, the ligatures may persist for a long time. He had never known them arrested by granulations. M. Marjolin had, however, met with cases in which the granulations had caused the delay; and it had been necessary to remove the ligature at its knotted end, because the exuberant granulations had covered it in a kind of tunnel, whence its removal became difficult without lacerating the granulations and causing them

to bleed.—*Med. Times and Gaz.*, March 6, 1875, from *L'Union Médicale*, Feb. 23.

Ovariectomy during Pregnancy.—Dr. THOMAS KEITH exhibited, at a late meeting of the Medico-Chirurgical Society of Edinburgh (*Edin. Med. Journ.*, January, 1875), an ovarian tumour which he had removed from a patient in the fifth month of pregnancy. It was of rapid growth, and had been tapped three weeks before operation. The patient had done well. He further drew the attention of the members to the fact that he had now performed ovariectomy 190 times, with a mortality, during the last three years, of under ten per cent.

Ablation of the Inverted Uterus taken for Polypus.—A series of interesting articles has lately been published in *L'Union Médicale* on uterine polypi. Among the examples of wrong diagnosis the author mentions a case in which the inverted uterus felt to the finger like a polypus. The surgeon slipped the chain of the écraseur on the neck of the supposed polypus, and removed it. The mass proved to be the whole inverted uterus. The attacks of metrorrhagia ceased, and the patient did well. Petit is said to have made the same mistake. Vieussens also removed the uterus under the same impression; the patient lived for ten years after the operation. The post-mortem examination showed that a small piece of the cervix had been left. The same misfortune happened to Bouchet, Slevogt, Boyer, and Jobert de Lamballe. The latter surgeon, when pulling down the mass with the vulsellum, perceived that he had to do with the uterus; he resisted, but the traction caused peritonitis, which carried off the patient.—*Lancet*, Feb. 13, 1875.

A Supposed Case of Renal Calculus.—Mr. ANNANDALE communicated this case to the Medico-Chirurgical Society of Edinburgh (*Edin. Med. Journ.*, Jan. 1875). The chief points to which he drew attention were the well-marked nature of the symptoms, the safety with which, by means of antiseptic precautions,

he was enabled to cut down on the kidney; and also that, although he had been unable to find any calculus, the distressing pains had been effectually removed by the operation. This last fact he thought could be explained by supposing that the incision acted as a strong counter-irritant.

On Unsuspected Calculi in the Bladder.

—Mr. JOHN FOSTER reports (*The Lancet*, October 10, 1874) the case of a gentleman, aged seventy-six, who had a narrow stricture at the orifice of the urethra. He had considerable frequency in making water, but had suffered no pain, and never passed any blood. The stricture was divided, and a catheter introduced to ascertain if he emptied his bladder. With the urine came a large number of very small calculi, and, by injecting warm water, over a thousand were washed out. They had never caused him any inconvenience.—*London Med. Record*, Dec. 30, 1874.

Avulsion of the Scalp.—Mr. BOUTFLOWER showed to the Manchester Medical Society, Dec. 2d, 1874, a case in which the entire scalp had been torn off by machinery, and in which the skin had been successfully reproduced by means of transplantation.—*Brit. Med. Journ.*, Feb. 6, 1875.

On a New Method of Estimating the Quantity of Pepsin by the Colour.—P. GRÜTZNER describes this method in *Pflüger's Archiv*, vol. viii. (abstract in *Centralblatt für die Medicin. Wissenschaften*, No. 20, 1874). Fibrin is to be coloured by placing it in a solution of carmine, then immediately preserved in glycerine, and before making an experiment, after washing away the glycerine, it is placed in dilute hydrochloric acid (two per cent.) until it swells up. By this means a beautiful red coloured jelly-like mass is obtained, which is easily dissolved in digesting fluid, and just in the degree to which it dissolves is it coloured red. The greater quantity of pepsin in the fluid to be investigated, the quicker does the solution of fibrin take place (*cæteris paribus*), and therewith the red colouring of the fluid. This method is as equally well fitted for the detection of small quan-

ties of pepsin, as for the comparison of the quantity of pepsin in two fluids.—*London Med. Record*, Jan. 6, 1875.

Mode of Formation of Urea in the Body.

—In the last part of the *Zeitschrift für Biologie* (Band x., Heft 3) Dr. KNIERIEM gives the results of a series of observations and investigations he has made to determine the origin of urea in the body. Shortly stated, they are to the following effect: 1. Ammonia is excreted by the urine under normal conditions, though in what precise condition is unknown. Its quantity is slightly increased when ammonia is taken internally. By far the largest part, however, leaves the economy as urea, and ammonia therefore, like leucine, is to be regarded as an antecedent of urea in economy. 2. Asparaginic acid and asparagin also undergo metamorphosis into urea in the body. They may with most certainty be regarded as antecedents of urea when they appear amongst the products of the artificial digestion of the proteids, or when they are formed in any other way in the economy. 3. Sal ammoniac is retained longer in the organism than asparaginic acid or its amid, and this especially holds good in regard to the chlorine. 4. No conclusions can be drawn in regard to the behaviour of any substance in the body from its chemical composition. A special series of experiments is required to determine this for each substance.—*Lancet*, Jan. 16, 1875.

Improved Elastic Tourniquet.—Dr. DAVID FOULIS, at a recent meeting of the Glasgow Pathological and Clinical Society (*British Med. Journ.*, Feb. 6, 1875), showed an instrument he had devised, which was now made and kept by Hilliard. It supplied a want felt in applying Es-march's elastic band, namely, a simple and efficient means of fastening the band at any point. It consists of two connected metal tubes: one to hold the band, the other to catch it at any degree of tension. To apply it, the band is stretched across the limb, the catch being in the middle; the ends are then passed under and around the limb, and brought up and slipped into the slit of the upper tube,

while on the stretch. The expansion of the India-rubber, on relaxation, fixes the ends firmly in the catch. To remove the pressure, the ends are stretched, and, while thus narrowed, are lifted out of the slit. Dr. Foulis showed various applications of this tourniquet on a patient (for amputation at the shoulder-joint, upper part of the thigh, etc.). He said that the elastic tourniquet prevented bleeding from the veins, as well as the arteries, without any previous bandaging of the limb being required, provided the limb were elevated for a short time before its application, so as to remove engorgement; the veins were thus converted into tubes closed at the upper end. He also said this catch allowed a relaxation of the pressure to be made gradually, so as to guide the surgeon in the tying of the smaller arteries cut at an amputation; by putting one of the turns on loosely and the other more tightly, the latter could be removed at the desire of the surgeon in the picking up of the arteries. There had, however, been no opportunity as yet of testing the instrument in actual operation.—Various members tested the efficiency of the catch, and expressed their satisfaction with its simplicity and freedom from slipping.—Dr. ALEXANDER PATTERSON thought such a portable tourniquet, so efficiently and so easily and rapidly applied, would form a valuable instrument for military practice on the field.

Outbreak of Puerperal Fever.—Our attention has been directed to a severe outbreak of puerperal fever in the neighbourhood of Wandsworth-road and Battersea-park. We have personally investigated the circumstances of the death of four of the cases, and learned particulars of several others. The cases seem to have occurred in the practice of one midwife, and in the four instances above alluded to she was distinctly the source of the infection. The duty of the medical men in the neighbourhood is obvious: they should refuse to sign any certificate of death in any case of puerperal fever occurring in the practice of this midwife, and thus compel the coroner to hold an inquest. This has been

done as yet in only one case, and at the time of our visit we learned that the coroner had refused to take cognizance of the death. At Coventry, where a similar outbreak has taken place, we learn with satisfaction that a midwife, Elizabeth Ingram, has been committed for trial on a charge of manslaughter by a coroner's jury for communicating puerperal fever to her patients. It appears she had been warned by the coroner on December 1st to abstain from practice, but did not do so. Since then two inquests have been held in fatal cases attended by her. Such examples are sadly wanted, and the coroner of the Wandsworth district will, in our judgment, be neglecting his duty if he does not attempt to prevent this woman continuing to bring death and desolation into the homes of her poor patients, who, ignorant of the fatal poison attached to her, solicit her aid.—*Lancet*, Jan. 16, 1875.

On the Effect of Electricity on the Spawn of the Frog.—M. ONIMUS, in a recent communication to the Société de Biologie, of Paris, states by electrifying the eggs of the frog, the development of those which are in connection with the negative pole will be accelerated, whilst the hatching of those in connection with the positive pole will be either retarded or stopped.—*London Med. Record*, Nov. 4, 1874.

Bacteria.—MM. TRAUBE and GOSCHEIDLEN write to *Dingler's Polytechnic Journal*, to state that the bacteria, which adhering to water give rise to putrefaction in dead organic matter, are killed if injected, even in large quantities, into the circulating system of living animals. Thus, blood drawn from a rabbit, into which $1\frac{1}{2}$ cubic centimetres of a fluid containing bacteria had been injected twenty-four hours previously, did not putrefy for months, a proof that the injected bacteria had been destroyed in that short time. From these data and similar, they conclude that the putrefactive bacteria are not to be found in the infectious poisons hitherto looked upon as dangerous. In their action they differ altogether from the contagious bacteria (viz., of spleen inflammation, smallpox) which cause pyæmia. Accord-

ing to Davaine, the 1-100,000 part of a drop of splenic inflammation blood is sufficient to develop splenic inflammation in a healthy animal (this blood contains the bacterium known as *Bacillus anthracis*). The circumstance, that, if putrefactive bacteria do not exist in the animal organism, they are destroyed therein, is indeed an essential condition of the continuance and progression of the entire organic world.—*The Sanitary Record*, March 6, 1875.

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Extraction of a Leech from the Larynx.

—In the *Gazzetta Medica Italiana*, No. 48, 1874, Prof. Vanzetti, of Padua, reports for Dr. GESUALDO CLEMENTI, of Caltagirone, Sicily, the following remarkable case: On August 15, 1874, the latter was called to a patient who had been suffering for a fortnight from cough and hæmoptysis. She was a woman of fifty-eight, who had always enjoyed previous good health, and had never had anything the matter with her chest before. She was now quite aphonic, and had repeated attacks of severe dyspnoea. On examination of the pharynx nothing was found which would account for the symptoms, and with the exception of slight recession of the lower intercostal spaces during inspiration, and a few râles at the bases of the lungs, nothing abnormal could be discovered in the chest. As the paucity of physical signs rendered it improbable that the hæmoptysis was due to a tubercular process in the lungs, or the aphonia to tubercular ulceration of the larynx, the throat was at once examined with the laryngoscope, in the hope that the diagnosis might be cleared up by its means. It was then found that the opening of the glottis was occupied by a leech, which was attached to the superior extremity of the right arytenoid cartilage by its oral disk. Only the first few rings of its body could be seen during tranquil respiration, since the remainder was hidden beneath the vocal cords; and later observations rendered it probable that the posterior sucker was fixed to the hinder wall of the trachea, a little above the cricoid cartilage. Numerous attempts were made on the same day to remove the animal with a pair of

laryngeal forceps, but they all proved futile; partly because the body of the leech so nearly filled the opening of the glottis that there was not space for the passage of the forceps; and partly, and to a still greater degree, on account of the tenacity with which the leech adhered to the interior of the larynx. On the next day, August 16, Dr. Clementi again made an effort to extract it, and this time with success. By using a pair of forceps with small recurved teeth, and by making the patient expire deeply, he was able, as the leech had not changed its position since the previous day, to seize the middle of its body, and to draw it upwards as high as the base of the tongue, and at a second trial to detach the oral disk from the arytenoid cartilage, and to draw the animal up into the mouth. An assistant then seized it with a pair of nasal polypus forceps, and at last succeeded, by twisting the body on its axis, in detaching the posterior sucker, and freeing the larynx of its dangerous tenant. The patient was immediately able to speak out loud and to breathe freely. In answer to the question how the leech could have entered the larynx, she stated that she remembered one day having placed some lettuces near a vessel containing drinking water, and that the leech had probably fallen out of the lettuces into the water. The leech was found to be the *hirudo sanguisorba*, commonly known as the horse-leech, which differs from the medicinal leech in adhering firmly for many days after it is gorged with blood. Dr. Clementi points out, in commenting on the case, that it completely negatives the ordinary idea that the continued presence of a foreign body in contact with the mucous membrane of the larynx will produce spasm of the glottis intense enough to suffocate the patient. He calculates that a force of more than two kilogrammes was required to detach the leech. This is the third case in which a leech has been discovered in the larynx, and extracted by the help of the laryngoscope. Dr. Trolard reported the first case in *L'Algérie Médicale*, 1870, No. 29; and Dr. Massei the second, in the *Morgagni*, October, 1874, p. 750.—*Med. Times and Gaz.*, Jan. 16, 1875.

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